Early Hearing Detection and Intervention Direct Referral Form for Diagnostic Audiology Evaluation

Communicating Did Not Pass Results

Congratulations on the birth of your baby. We just finished screening your baby's hearing. Your baby did not pass two hearing screenings. This does not necessarily mean that your baby has a hearing loss, but without additional testing we can't be sure. Funding for follow-up testing can be found through private insurance, Medicaid, Children's with Special Healthcare Services (CSHCS), or private pay. If you would like to use Medicaid, private insurance, or pay for the services yourself, we will help you make the follow-up appointment before you leave the hospital. If you are interested in applying for CSHCS, we will assist you in getting the appropriate paperwork. If this form is being provided after hours or on the weekend, the hospital staff will be contacting you at home with the time and date of the appointment.

Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Please cut and paste appropriate and current Level 1 Centers

Appointment: ☐ Scheduled ☐ Needs to be Scheduled ☐ Interpreter-Type Needed: _____

Date: _____ Time: _____

Newborn Information

Name: _____ Date of Birth: _____

Birthing Facility: _____ Screening Facility: _____

Hearing Screening Date: _____ MRN: _____

Hearing Screening Results: Right ☐Pass ☐Refer Left ☐Pass ☐Refer

Funding for follow-up: ☐ Medicaid ☐ Self Pay ☐ Private Insurance _____

Parent/Guardian Contact Information

Name: _____ Language Spoken at Home: _____

Address: _____

Phone #: _____ Alternate Phone #: _____

Alternate Contact (Friend/Relative)

Name: _____ Alternate Phone #: _____

Primary Care Provider

Name: _____ Phone #: _____

Diagnosis: Suspected Hearing Loss **Diagnosis Code**: 389.9 **This order is valid for six (6) months from the date ordered.**

Physician Authorizing Diagnostic Audiology Evaluation As the Primary Care Provider, you must sign below and fax back to the facility selected above at least 7 days before the above scheduled appointment or it will be cancelled. Signature must be that of the physician. A copied signature is acceptable.

Physician Signature: _____ Date: _____